



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://exchange.imperialhealthplan.com/texas/> or contact us at 1-800-595-0619 or <https://exchange.imperialhealthplan.com/texas/contact-information/>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://exchange.imperialhealthplan.com/texas/members> or call 1-800-595-0619 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                         | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0 at Indian Health Care Provider (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or \$800 per person   \$1600 per group                                                                                                                                                                                                             | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                             |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary care, <a href="#">specialist</a> visits, <a href="#">preventive care</a> , generic drugs, preferred drugs, <a href="#">urgent care</a> , outpatient mental, behavioral, or substance abuse services, office visits while pregnant, child eye care, child dental care, are covered before meeting your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">percentage copayment</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-carebenefits/">https://www.healthcare.gov/coverage/preventive-carebenefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                                                             | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$3600 per person   \$7200 per group                                                                                                                                                                                                                                                                                                            | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                                                                                    | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.imperialhealthplan.com/texas/hmo-exchange/provider-directory">https://www.imperialhealthplan.com/texas/hmo-exchange/provider-directory</a> or call 1-800-838-5914 for                                                                                                                                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some                                 |

| Important Questions                                                          | Answers                                       | Why This Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | a list of <a href="#">network providers</a> . | services (such as lab work). Check with your <a href="#">provider</a> before you get services.                                                                                                                       |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes.                                          | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |

 All [copayment](#) and [percentage copayment](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                        | Services You May Need                                  | What You Will Pay                                              |                                                     |                                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                             |                                                        | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                |
| If you visit a health care <a href="#">provider's</a> office or clinic                                      | Primary care visit to treat an injury or illness       | No Charge                                                      | \$20 <a href="#">copay</a> /visit                   | Not covered                                                 | NoneCost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                       |
|                                                                                                             | <a href="#">Specialist</a> visit                       | No Charge                                                      | \$40 <a href="#">copay</a> /visit                   | Not covered                                                 |                                                                                                                                                                                                                                                                |
|                                                                                                             | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                      | No Charge                                           | Not covered                                                 | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> . |
| If you have a test                                                                                          | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | NoneCost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                                       |
|                                                                                                             | Imaging (CT/PET scans, MRIs)                           | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 |                                                                                                                                                                                                                                                                |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription</a> | Preventive drugs (Tier 1)                              | No Charge                                                      | No Charge                                           | Not Covered                                                 | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). <a href="#">Preauthorization</a> is required for certain drugs. Cost sharing waived at non-IHCP with                                                           |
|                                                                                                             | Generic drugs (Tier 2)                                 | No Charge                                                      | \$10 <a href="#">copay</a> /prescription            | Not covered                                                 |                                                                                                                                                                                                                                                                |
|                                                                                                             | Preferred brand drugs (Tier 3)                         | No Charge                                                      | \$20 <a href="#">copay</a> /prescription            | Not covered                                                 |                                                                                                                                                                                                                                                                |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/texas/individual-eoc/>

| Common Medical Event                                                                                                                                                                                                                                                        | Services You May Need                            | What You Will Pay                                           |                                                  |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                             |                                                  | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                |
| <a href="https://client.formularynavigator.com/Search.aspx?siteCode=5261847175">drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=5261847175">https://client.formularynavigator.com/Search.aspx?siteCode=5261847175</a> | Non-preferred brand drugs (Tier 4)               | No Charge                                                   | \$60 <a href="#">copay</a> /prescription         | Not covered                                              | IHCP <a href="#">referral</a> .                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                             | <a href="#">Specialty drugs</a> (Tier 5)         | No Charge                                                   | \$250 <a href="#">copay</a> /prescription        | Not covered                                              |                                                                                                                                                                                                                                                |
| If you have outpatient surgery                                                                                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center)   | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              | <a href="#">Preauthorization</a> is required. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                             |
|                                                                                                                                                                                                                                                                             | Physician/surgeon fees                           | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              |                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                                                                                                                                                                                                                     | <a href="#">Emergency room care</a>              | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | 30% <a href="#">percentage copayment</a>                 | NoneCost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                             | <a href="#">Emergency medical transportation</a> | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | 30% <a href="#">percentage copayment</a>                 |                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                             | <a href="#">Urgent care</a>                      | No Charge                                                   | \$30 <a href="#">copay</a> /visit                | \$30 <a href="#">copay</a> /visit                        |                                                                                                                                                                                                                                                |
| If you have a hospital stay                                                                                                                                                                                                                                                 | Facility fee (e.g., hospital room)               | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              | All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units; <a href="#">Preauthorization</a> is required. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .              |
|                                                                                                                                                                                                                                                                             | Physician/surgeon fees                           | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              |                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services                                                                                                                                                                                                   | Outpatient services                              | No Charge                                                   | \$20 <a href="#">copay</a> /visit                | Not covered                                              | NoneCost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                             | Inpatient services                               | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              |                                                                                                                                                                                                                                                |
| If you are pregnant                                                                                                                                                                                                                                                         | Office visits                                    | No Charge                                                   | No Charge                                        | Not covered                                              | Cost sharing does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">percentage copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., |
|                                                                                                                                                                                                                                                                             | Childbirth/delivery professional services        | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              |                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                             | Childbirth/delivery facility services            | No Charge                                                   | 30% <a href="#">percentage copayment</a>         | Not covered                                              |                                                                                                                                                                                                                                                |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/texas/individual-eoc/>

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                              |                                                     |                                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                               |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                      |
|                                                                       |                                           |                                                                |                                                     |                                                             | ultrasound). Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> . |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | 60 visits per year Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                              |
|                                                                       | <a href="#">Rehabilitation services</a>   | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | 35 visits per year. Includes chiropractic, physical therapy, speech therapy, and occupational therapy Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                           |
|                                                                       | <a href="#">Habilitation services</a>     | No Charge                                                      | \$20 <a href="#">copay</a> /visit                   | Not covered                                                 |                                                                                                                                                                                                                      |
|                                                                       | <a href="#">Skilled nursing care</a>      | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | 25 visits per year Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                              |
|                                                                       | <a href="#">Durable medical equipment</a> | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                           |
|                                                                       | <a href="#">Hospice services</a>          | No Charge                                                      | 30% <a href="#">percentage copayment</a>            | Not covered                                                 | <a href="#">Preauthorization</a> is required. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No Charge                                                      | No Charge                                           | Not covered                                                 | Coverage limited to 1 exam/year. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                                |
|                                                                       | Children's glasses                        | No Charge                                                      | No Charge                                           | Not covered                                                 | Coverage limited to 1 pair of glasses/year. Cost sharing waived at non-IHCP with IHCP <a href="#">referral</a> .                                                                                                     |
|                                                                       | Children's dental check-up                | No Charge                                                      | No Charge                                           | Not covered                                                 | Coverage limited to 2 dental check-ups & cleanings/calendar year. Cost                                                                                                                                               |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/texas/individual-eoc/>

| Common Medical Event | Services You May Need | What You Will Pay                                              |                                                     |                                                             | Limitations, Exceptions, & Other Important Information          |
|----------------------|-----------------------|----------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|
|                      |                       | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                 |
|                      |                       |                                                                |                                                     |                                                             | sharing waived at non-IHCP with IHCP <a href="#">referral</a> . |

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment (except diagnosis of the medical cause and surgery to treat medical cause)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (limited to 35 visits per year)
- Hearing aids (once every 3 years)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Imperial Insurance Companies at 1-800-595-0619. You may also contact the Texas Department of Insurance at 1-800-578-4677 at 333 Guadalupe Street, Austin, TX 78707 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance at 1-800-578-4677 or visit <https://www.tdi.texas.gov>. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Texas Department of Insurance at 1-800-252-3439.

**Does this [plan](#) provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this [plan](#) meet the Minimum Value Standards? Not Applicable.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-595-0619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-595-0619.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-595-0619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-595-0619.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [percentage copayments](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$800
- [Specialist percentage copayments](#) \$40
- Hospital (facility) [percentage copayments](#)
- Other [percentage copayments](#)

This EXAMPLE event includes services like:

[Specialist](#) office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (ultrasounds and blood work)  
[Specialist](#) visit (anesthesia)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a>           | \$1,300        |
| <a href="#">Copayments</a>            | \$0            |
| <a href="#">Percentage Copayments</a> | \$2,000        |
| What isn't covered                    |                |
| Limits or exclusions                  | \$60           |
| <b>The total Peg would pay is</b>     | <b>\$3,360</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$800
- [Specialist percentage copayments](#) \$40
- Hospital (facility) [percentage copayments](#)
- Other [percentage copayments](#)

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable medical equipment](#) (glucose meter)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a> *         | \$900          |
| <a href="#">Copayments</a>            | \$300          |
| <a href="#">Percentage Copayments</a> | \$0            |
| What isn't covered                    |                |
| Limits or exclusions                  | \$20           |
| <b>The total Joe would pay is</b>     | <b>\$1,220</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$800
- [Specialist percentage copayments](#) \$40
- Hospital (facility) [percentage copayments](#)
- Other [percentage copayments](#)

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic test](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a> *         | \$1,300        |
| <a href="#">Copayments</a>            | \$200          |
| <a href="#">Percentage Copayments</a> | \$200          |
| What isn't covered                    |                |
| Limits or exclusions                  | \$0            |
| <b>The total Mia would pay is</b>     | <b>\$1,700</b> |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-595-0619

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.